Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SIERRA MEDICAL CENTER
LAW OFFICES OF P MATTHEW ONEIL
6514 MCNEIL DR BLDG 2 STE 201
AUSTIN TX 78729-7710

Respondent Name
ZURICH AMERICAN INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-1024-01

MFDR Date Received
December 2, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the Hospital's contract with the CorVel network, Specialty Risk Services ("SRS" or "the Carrier") should have paid 55% of the total billed charges of $45,215.11, or $24,868.31. However, only $5,436.34 has been paid to date, leaving a remaining unpaid variance of $19,431.97. The Hospital thus seeks reimbursement from the Carrier of the variance due of $19,431.97 plus interest. . . . Only recently, CorVel, by the attached letter of 10/21/2011, alleges that SRS was not a participating payer in the CorVel network. Apparently the Carrier improperly or fraudulently applied the CorVel network discount on only 2 line items as a basis for reimbursement, rather than the entire bill. Thus, Subclaimant files this request for medical fee dispute alternatively to its contractual remedies. However, the Hospital does not waive its contractual remedies under the network agreement or its common law claims, due to the payer's improper and apparent accessing of a network in which it was not a participating payer."

Amount in Dispute: $19,431.97

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier initially reimbursed the provider $5436.34. The carrier received allowed an additional $2762.14, for a total of $8198.48. The carrier submits this amount is consistent with the applicable fee guidelines. . . . the requestor acknowledges receiving a letter dated October 21, 2011 indicating there was not a network contract applicable to this particular claim. The requestor has provided absolutely no documentation of other evidence suggesting a contract should apply to the present claim. . . . When the carrier first audited the disputed medical bill, it allowed $5436.34 in reimbursement after applying a PPO discount of $2762.14. After it was determined that a network contract did not apply to this case, and a PPO discount was not appropriate, the carrier re-audited the medical bill (see attached EOB dated December 6, 2011), and allowed an additional $2762.14. No additional reimbursement is due at this time."

Response Submitted by: Flahive, Ogden & Latson, Post Office Drawer 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 7, 2010	Outpatient Hospital Services	$19,431.97	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - W1 – Workers Compensation State Fee Schedule Adjustment.
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - 18 – Duplicate claim/service.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.
   - W3 – Additional payment made on appeal/reconsideration.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced/denied payment for disputed services with reason code 45 – "Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code C1751 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
   - Procedure code C1778 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
   - Procedure code L8699 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

- Procedure code 72080 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $44.90. This amount multiplied by 60% yields an unadjusted labor-related amount of $26.94. This amount multiplied by the annual wage index for this facility of 0.8555 yields an adjusted labor-related amount of $23.05. The non-labor related portion is 40% of the APC rate or $17.96. The sum of the labor and non-labor related amounts is $41.01. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service is $41.01. This amount multiplied by 200% yields a MAR of $82.02.
- Procedure code 76000 has a status indicator of Q1, which denotes STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X that are billed for the same date of service. This code may be separately payable only if no other such procedures are billed for the same date. Review of the submitted information finds that OPPS criteria for separate payment have not been met. Payment for this service is included in the payment for other procedures billed on the same date of service. The use of a modifier is not appropriate. Separate reimbursement is not recommended.
- Procedure code 63650 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0040, which, per OPPS Addendum A, has a payment rate of $4,429.21. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,657.53. This amount multiplied by the annual wage index for this facility of 0.8555 yields an adjusted labor-related amount of $2,273.52. The non-labor related portion is 40% of the APC rate or $1,771.68. The sum of the labor and non-labor related amounts is $4,045.20. Per 42 Code of Federal Regulations §419.43(d) and *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,175, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.097. This ratio multiplied by the billed charge of $9,734.66 yields a cost of $944.26. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $4,045.20 divided by the sum of all APC payments is 99.00%. The sum of all packaged costs is $3,406.66. The allocated portion of packaged costs is $3,372.47. This amount added to the service cost yields a total cost of $4,316.73. The cost of this service exceeds the annual fixed-dollar threshold of $2,175. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The outlier payment amount is $0.00. The total APC payment for this service is $4,045.20. This amount multiplied by 200% yields a MAR of $8,090.40.
- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J1100 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J1170 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

4. The total allowable reimbursement for the services in dispute is $8,172.42. This amount less the amount previously paid by the insurance carrier of $8,198.48 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	October 30, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.